PEDIATRIC DENTAL ACQUAINTANCE FORM

Date _____

Demographic Information

Patient's Name _____ Name they would like to be called _____

Age _____ Birth date _____ Social Security Number _____ Sex (Circle one) F M

Address _____
(Street) (City) (State) (Zip Code)

Home Phone # (____)_____ Names & ages of siblings _____

Mother's Name _____ Social Security # _____ DOB _____

Mother's Employer _____ Work Phone # (____)_____ Mobile Phone # (____)_____

Father's Name _____ Social Security # _____ DOB _____

Father's Employer _____ Work Phone # (____)_____ Mobile Phone # (____)_____

Who has legal custody of patient? _____ Patient lives with: Mother Father Both Other _____

Child's Physician _____ Phone # (____)_____ Date of last exam _____

Whom may we thank for referring you to us? _____

How did you hear about our office: ☐ Internet/Website ☐ Friend_____ ☐ Physician/Dentist_____ ☐ Other _____

Please provide the email address(es) of those who would like to receive appointment confirmation emails:

Email Address: _____ (Mother / Father / Other_____)

Email Address: _____ (Mother / Father / Other_____)

What is the reason for today's visit? _____

Health History

YES	NO	
___	___	Has your child ever had a health problem? Please explain_____
___	___	Has your child ever been hospitalized? Please give reason and dates_____
___	___	Is your child allergic to anything?_____
___	___	Is your child currently taking any medications? Please give medication and reason _____
		_____
___	___	Were there any problems at birth?_____

Please check if your child has been treated for any of the following:

___ Heart disease	___ Liver disease	___ Kidney disease	___ Bleeding/transfusion
___ Asthma	___ Anemia	___ Rheumatic fever	___ Seizures
___ Diabetes	___ Hepatitis	___ Cerebral palsy	___ Cleft lip/palate
___ AIDS	___ Depression	___ ADHD/ADD	___ Learning Disability
___ Speech/hearing	___ Other Problems (Please explain) _____		

Do you consider your child to be:
___ advanced in the learning process
___ progressing normally
___ slow in the learning process

Infant Feeding History: Was your child breast fed? Yes / No (Circle one) At what age was it stopped? _____
Was your child bottle fed? Yes / No (Circle one) At what age was it stopped? _____

Dental History

YES NO

___ ___ Has your child ever been seen by a dentist? Name of dentist_____

Date of last visit _____ Dentist's phone number_____

___ ___ Has your child experienced any unfavorable reaction from previous dental care?

If yes, please explain _____

___ ___ Does your child suck a: ☐ thumb ☐ finger(s) ☐ pacifier ☐ other _____

___ ___ Does your child have pain with chewing, yawning or wide opening? _____

___ ___ Does your child's jaw make noise and is pain associated with the sounds? _____

Please check if your child is having problems with any of the following:

___ Cavities ___ Toothache ___ Teeth are sensitive ___ Color of teeth

___ Trauma ___ Gum infections ___ Orthodontics ___ Other _____

Fluoride History

YES NO

___ ___ Is your drinking water fluoridated? (Your water is fluoridated if you pay a "City of Durham" or "OWASA" water bill.)

___ ___ Do you use well water in your home? If yes, has it been analyzed for fluoride? (Circle one) Yes / No

___ ___ Does your child use a fluoride toothpaste?

___ ___ Do you give your child any other form of fluoride? What? _____

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Consent of Dental Treatment

I request and authorize Durham Pediatric Dentistry & Orthodontics to examine, clean and provide dental treatment on my child's teeth. I further request and authorize the taking of dental x-rays as may be considered necessary by Dr. Christensen or Dr. Swinney to diagnose and/or treat my child's dental problem. I will allow photographs to be taken of my child or child's teeth for diagnostic & academic purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Dr. Christensen & Dr. Swinney will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice tone.

Signature _____ **Relationship to patient** _____ **Date**_____

Payment Policy

I will be responsible for any charges incurred on this child for dental treatment. I understand that by failing to make payments to Durham Pediatric Dentistry & Orthodontics my account can be turned over to a collection agency. Durham Pediatric Dentistry & Orthodontics will no longer provide dental care for my child 30 days after turn over. In cases of divorce, the custodial parent is responsible for any charges incurred.

Signature _____ **Relationship to patient** _____ **Date**_____
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